

FILED JUN 10 1949  
 Registration District No. 149

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
 (c) Name of hospital or institution:  
K.C. General Hospital No. 1 D  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
 In this community 40 yrs  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 3  
 (If outside city or town limits, write "RURAL") 8  
 (d) Street No. 3905 East 18th St. 0  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Bryant

3. (b) If veteran, name war ✓ NO 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dora E Bryant 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Jan 4 1865  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>3</u>	<u>28</u>	hr. _____ min.

9. Birthplace Trace Lake Ill  
 (City, town, or county) (State or foreign country)

10. Usual occupation retired car referrer

11. Industry or business Mo Pac R R

MOTHER FATHER

12. Name Silas Bryant

13. Birthplace doul Ind 9  
 (City, town, or county) (State or foreign country)

14. Maiden name Roseetta

15. Birthplace doul Ind 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Dora E Bryant  
 (b) Address 3905 E 18

17. (a) none (b) Date thereof May 4-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Geo F Porter  
 (b) Address 915 2110

19. (a) 5-3-43 (b) M. M. Grove  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd  
 year 1943 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5-1-43, 19, to 5-2-43, 19, that I last saw him alive on 5-2-43, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (a) Means of injury \_\_\_\_\_

23. Signature Dr. R. J. Shaw (M. D. or other) \_\_\_\_\_  
 Address Med. Dir. J.C. Gen. Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Geo F Porter*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Geo F Porter*

Licensed Embalmer No. *3659*.....

P. O. Address *Kansas City, Mo*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.